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Electroconvulsive Therapy Prior Authorization Request Form

Upon completion, please return by fax to: 1-844-887-6357.

Member name:		
Member ID:		
Reference number (if known):		
DOB:		
Inpatient or outpatient?	☐ Inpatient ECT	☐ Outpatient ECT
Treatment request for:	☐ Initial treatment	☐ Continuation of treatment
Dates of service requested (start-end):		
Number of treatments requested:		
Facility concurrent reviewer name, phone/fax:		
Discharge planner name, phone/fax:		

Medical clearance for ECT treatment

	Provider name	Date	Assessment completed
Medical clearance:			☐ Inpatient ☐ Outpatient
Second opinion:			☐ Inpatient ☐ Outpatient

Diagnoses (Include all behavioral and physical health.)

Reason member was referred for ECT

Risk assessment (SI/HI/psychosis) — current MSE

Substance use assessment

Treatment history

Current treatment team	**Name**	**Phone**
PCP		
Psychiatrist		
Anesthesiologist		
Psychologist		
ARNP		
Social worker		
Other		

History of inpatient treatment
Treatment compliance
Social support (Who will care for the member following treatment?)
Current medication(s) (Include BH, PH and history of medications tried in the past.)
Does member have a history of poor response to several trials of antidepressants in adequate doses for a sufficient amount of time?
☐ Yes ☐ No If yes, please provide details:
Does member have a history of good response to ECT during an earlier episode of illness?
☐ Yes ☐ No If yes, please provide details:
Does member have a history of adverse effects with medications that are deemed to be less likely and/or severe with ECT?
☐ Yes ☐ No If yes, please provide details:

ECT treatment record

Date	Provider name	Pre-treatment score (QID, PHQ-9, etc.)	Unilateral/bilateral	Seizure duration	Response